



## Application for Medicare Australia Provider/Registration number for an Allied Health Professional

Please print clearly and complete all sections.

This application will be returned if all relevant documentation/information has not been supplied.

### Section 1—Personal details

Title Dr  Mr  Mrs  Ms  Miss  Other (please specify)

Family name

Given names

Date of birth (DD/MM/YYYY)  /  /

Gender

Please quote any existing provider/registration number Medicare Australia has issued to you (not those issued by the Department of Veterans' Affairs and Office of Hearing Services).

### Section 2—Qualifications

Please select your allied health profession by placing a cross in the applicable box

AHP Type	
<input type="checkbox"/>	Aboriginal Health Worker
<input type="checkbox"/>	Audiologist
<input type="checkbox"/>	Chiropodist
<input type="checkbox"/>	Chiropractor
<input type="checkbox"/>	Diabetes Educator

AHP Type	
<input type="checkbox"/>	Dietitian
<input type="checkbox"/>	Exercise Physiologist
<input type="checkbox"/>	Mental Health Worker
<input type="checkbox"/>	Occupational Therapist
<input type="checkbox"/>	Osteopath

AHP Type	
<input type="checkbox"/>	Physiotherapist
<input type="checkbox"/>	Podiatrist
<input type="checkbox"/>	Psychologist
<input type="checkbox"/>	Speech Pathologist

**Note:** One application form per profession.

Professional qualification

Place obtained  Year obtained

Languages spoken (other than English)

### Section 3—Personal contact details (email and/or mail address if different from practice location)

For this application only  For general mailout purposes

Telephone number (during business hours) ( ) <input type="text"/>	Street details <input type="text"/>
Mobile <input type="text"/>	Tick a box <input type="checkbox"/> GPO Box <input type="checkbox"/> PO Box <input type="checkbox"/> Number <input type="text"/>
Facsimile number ( ) <input type="text"/>	Suburb/Locality <input type="text"/>
Pager <input type="text"/>	State <input type="text"/> Postcode <input type="text"/>
	Email <input type="text"/>

#### Section 4—Registration/membership details

You must have current registration for any State or Territory in which you practise or provide evidence of eligibility in accordance with the eligibility requirements for the Medicare Allied Health and Dental initiative. Please attach a copy of documents confirming registration/membership with the relevant State or Territory Board or membership of a National Professional Association or relevant qualifications. Eligibility requirements can be found at [www.medicareaustralia.gov.au/providers/forms/medicare](http://www.medicareaustralia.gov.au/providers/forms/medicare) or by calling 132 150.

State or Territory	Registration/membership number	Date registered	Name of Society/Board or Association

#### Section 5—Required practice locations—must be a private practice

**Practice location:** A practice location is its physical location (not post office box) and is the address at which you render services.

Start date	(DD/MM/YYYY) / /	Practice name/Building			
End date	(if required) / /	Property/Department			
		Tick a box	Suite <input type="checkbox"/>	Unit <input type="checkbox"/>	Shop <input type="checkbox"/>
		Street details	Number <input type="text"/>	Floor number <input type="text"/>	
		Suburb/locality			
		State	<input type="text"/>	Postcode	<input type="text"/>
		Telephone number	( )		
		Facsimile number	( )		

Please attach a list if you are applying for additional locations.

Please close the following Medicare Australia Provider/Registration numbers:

Provider/Registration number	Address	Closing Date

#### Section 6—Declaration

I declare that, to the best of my knowledge and belief, all the information provided on this application form is true and correct.

Signature of applicant  Date signed / /

**Privacy Note:** Information provided by you on this form will be used to assess your application for a provider/registration number and to determine your eligibility to participate in the Medicare program. This information may be disclosed to the Department of Human Services, Department of Health and Ageing, Department of Veterans' Affairs, private health funds and other approved organisations or as authorised or required by law.

#### Lodgement details

When completed, your application may be posted to:

**Medicare Australia Provider Eligibility Section**  
**PO Box 9822 (in your capital city)**

OR

Your application can be sent by facsimile to:

NSW and ACT	(02) 9895 3439
VIC	(03) 9605 7984
QLD	(07) 3004 5634
SA	(08) 8274 9307
WA	(08) 9214 8201
TAS	(03) 6215 5700
NT	(08) 8922 6322

**Please note:**

- The application and supporting documentation should be submitted to Medicare Australia as soon as possible prior to your proposed commencement date.
- Where applications are faxed, you must retain your original documents for auditing purposes.

**Registration Enquiries:** Telephone 132 150 (8:30am to 5:00pm) or email [medicare.prov@medicareaustralia.gov.au](mailto:medicare.prov@medicareaustralia.gov.au)



## Application for EFT payments for an allied health professional direct payments

Please complete a separate application for each practice for which Medicare benefits are to be paid by EFT.

### Section 1—Allied health professional and location details

Provider/Registration no

Family name  First name

Address  Postcode

Telephone (  )  Facsimile (  )

Email

### Section 2—Financial Institution details

BSB no

Bank name and branch

Account no

Name in which account is held

### Section 3—Declaration

I, the applicant, being a registered allied health professional entitled to render professional services as defined in the *Health Insurance Act 1973*, apply to Medicare Australia to have Medicare benefits paid directly into the above mentioned account via electronic fund transfer (EFT).

Signature of practitioner

Dated this  day of  20

### Privacy Note

The information provided by you on this form will be used by Medicare Australia to identify your nominated financial institution details for the purposes of making electronic payments for Medicare direct payments. Your financial institution account details will be disclosed to the relevant financial institutions to facilitate payment of your claims.